(1) **Coding When Not a Restraint**

If a resident is able to easily open the front gate and exit the device, the device should **not** be coded as a restraint for this particular resident. It would be coded at Item G5a as a Cane/walker/crutch.

(2) **Coding When a Restraint**

(a) Only if the device has the effect of restricting the resident's freedom of movement, should the device be considered a restraint. If the resident's freedom of movement is restricted because the resident cannot open the front gate and exit the device (due to cognitive or physical limitations that prevents him or her from exiting the device), then the device should be coded as a restraint in Item P4 of the MDS.

(b) The current version of the MDS (Version 2.0) does not contain a category for a restraint in which this device obviously falls. We understand that these devices do not prevent a resident from standing. Nevertheless, until CMS releases the next version of the MDS, when the device restricts freedom of movement, code the device at Item P4e, Chair prevents rising, with either a "1" (Used less than daily), or a "2" (Used daily). In subsequent versions of the MDS, CMS will include an "other" category, which would be an appropriate place to code this type of device.

(c) Coding the device at Item P4e does not preclude the facility from also coding the device at Item G5a (Cane/walker/crutch) if the resident used the device to walk during the last 7 days.

Request for Restraints:

While a resident, family member, legal representative or surrogate may request that a restraint be used, the facility has the responsibility to evaluate the appropriateness of that request, as they would a request for any type of medical treatment. As with other medical treatments, such as the use of prescription drugs, a resident, family member, legal representative or surrogate has the right to refuse treatment, but not to demand its use when it is not deemed medically necessary. According to the Code of Federal Regulation (CFR) at 42 CFR 483.13(a), "The resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms." CMS expects that no resident will be restrained for discipline or convenience. Prior to employing any restraint, the nursing facility must perform a prescribed resident assessment to properly identify the resident's needs and the medical symptom the restraint is being employed to address. The guidelines in the State Operations Manual (SOM) state, "...the legal

surrogate or representative cannot give permission to use restraints for the sake of discipline or staff convenience or when the restraint is not necessary to treat the resident's medical symptoms. That is, the facility may not use restraints in violation of regulation solely based on a legal surrogate or representative's request or approval." The SOM goes on to state, "While Federal regulations affirm the resident's right to participate in care planning and to refuse treatment, the regulations do not create the right for a resident, legal surrogate or representative to demand that the facility use specific medical intervention or treatment that the facility deems inappropriate. Statutory requirements hold the facility ultimately accountable for the resident's care and safety, including clinical decisions."

Are Restraints Prohibited?

The regulations and CMS' guidelines do not prohibit the use of restraints in nursing facilities, except when they are imposed for discipline or convenience and not required to treat the resident's medical symptoms. The regulation states, "The resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms" (42 CFR 483.13(a)). Research and standards of practice show that the belief that restraints ensure safety is often unfounded. In practice, restraints have many negative side effects and risks that, in some cases, far outweigh any possible benefit that can be derived from their use. Prior to using any restraint, the facility must assess the resident to properly identify the resident's needs and the medical symptom that the restraint is being employed to address. If a restraint is needed to treat the resident's medical symptom, the facility is responsible to assess the appropriateness of that restraint. When the decision is made to use a restraint, CMS encourages, to the extent possible, gradual restraint reduction because there are many negative outcomes associated with restraint use. While a restraint-free environment is not a Federal requirement, the use of restraints should be the exception, not the rule.

Bed Rails Used as Positioning Devices:

In classifying any device as a restraint, the assessor must consider the effect the device has on the individual, not the purpose or intent of its use. It is possible for a device to improve the resident's mobility and also have the effect of restraining the individual. **If the side rail has the effect of restraining the resident and meets the definition of a physical restraint for that individual, the facility is responsible to assess the appropriateness of that restraint**. Prior to employing any restraint, the facility must assess the resident to properly identify the resident's needs and the medical symptom the restraint is being employed to address. When the facility decides that a restraint is needed to treat the resident's medical symptom, CMS encourages, to the extent possible, gradual restraint reduction because of the many negative outcomes associated with restraint use. While

bed rails may serve more than one function, the assessor should code Items P4a or P4b when the bed rails meet the definition of a restraint. When a bed rail is *both* a restraint *and* a transfer or mobility aid, it should be coded at Item P4 (a or b, as appropriate) *and* at Item G6b (Bedrails used for mobility or transfer).

Devices Used with Residents Who Are Immobile:

Side Rails - Physical restraints are defined as "any manual method, physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily that restricts freedom of movement or normal access to one's body." If the resident is immobile and can not voluntarily get out of bed due to a physical limitation and not due to a restraining device or because proper assistive devices were not present, the bed rails do not meet the definition of a restraint.

For residents who have no voluntary movement, the staff needs to determine if there is any appropriate use of bed rails. Bed rails may create a visual barrier and deter physical contact from others. Some residents have no ability to carry out voluntary movements, yet they exhibit involuntary movements. Involuntary movements, resident weight, and gravity's effects may lead to the resident's body shifting towards the edge of the bed. For this type of resident, clinical evaluation of alternatives (e.g., a concave mattress to keep the resident from going over the edge of the bed), coupled with frequent monitoring of the resident's position, should be considered. While the bed rails may not constitute a restraint, they may affect the resident's quality of life and create an accident hazard.

Geriatric Chairs - For a resident who has no voluntary or involuntary movement, the geriatric chair does not meet the definition of a restraint and should not be coded at Item P4e. If the resident has the ability to transfer from other chairs, but cannot transfer from a geriatric chair, a geriatric chair is a restraint to that individual, and should be coded at Item P4e. If the resident has no ability to transfer independently, then the geriatric chair does not meet the definition of a restraint, and should not be coded at Item P4e.

P5. Hospital Stay(s) (90-day look back)

Intent: To record how many times the resident was admitted to the hospital with an overnight stay in the last 90 days or since the last assessment if less than 90 days [regardless of payment status for these days either by the hospital or by the nursing facility]. If the resident is a new admission to the facility, this item includes admissions during the period prior to admission.

Definition: The resident was formally admitted by a physician as an inpatient with the expectation that he or she will stay overnight. It does not include day surgery, outpatient services, etc.

Process: Review the resident's record. If the resident is a new admission, ask the resident and resident's family. Sometimes transmittal records from recent hospital admissions are not readily available during a nursing facility admission from the community.

Coding: Enter the number of hospital admissions during the 90-day observation period prior to admission to the nursing facility. Enter "**0**" if no hospital admissions.

Examples

Mrs. D, an insulin-dependent diabetic, was admitted to the nursing facility yesterday from her own home. At home she had been having a lot of difficulty with insulin regulation since developing an ulcer on her left foot six weeks ago. During the last 90 days prior to admission, Mrs. D had two hospitalizations, for 3 and 5 days respectively. **Code "2" for two hospital admissions in the last 90 days.**

Mr. W has been a resident of the nursing facility for two years. He has a blood dyscrasia and receives transfusions at the local emergency room twice monthly. In the last month, Mr. W was admitted to the hospital for 2 days after developing a fever during his blood transfusion. **Code "1" for one hospital admission in the last 90 days.**

P6. Emergency Room (ER) Visit(s) (90-day look back)

Intent: To record if during the last 90 days the resident visited a hospital emergency room (e.g., for treatment or evaluation) but was not admitted to the hospital for an overnight stay at that time. If the resident is a new admission to the facility, this item includes emergency room visits during the period prior to admission.

Definition: **Emergency Room Visit** - A visit to an emergency room not accompanied by an overnight hospital stay. Exclude prior scheduled visits for physician evaluation, transfusions, chemotherapy, etc.

Process: Review the resident's clinical record. For new admissions, ask the resident and the resident's family and review the transmittal record.

Coding: Enter the number of ER visits in the last 90 days (or since last assessment if less than 90 days). Enter "**0**" if no ER visits.

Examples

One evening, Mr. X complained of chest pain and shortness of breath. He was transferred to the local emergency room for evaluation. In the emergency room Mr. X was given IV Lasix, nitrates, and oxygen. By the time he stabilized, it was late in the evening and he was admitted to the hospital for observation. He was transferred back to the nursing facility the next afternoon. **Code "0" for No ER visits.** The **rationale** for this coding is that although Mr. X was transferred to the emergency room, he was admitted to the hospital overnight. An overnight stay is not part of the definition of this item.

During the night shift, Mrs. F slipped and fell on her way to the bathroom. She complained of pain in her right hip and was transferred to the local emergency room for x-rays. The x-rays were negative for a fracture and Mrs. F was transferred back to the nursing facility within several hours. **Code "1" for 1 ER visit.**

Once during the last 90 days, Mr. P's gastrostomy tube became dislodged and nursing facility staff was unsuccessful in reinserting it after multiple attempts. Mr. P was then transferred to the local emergency room where the on-call physician reinserted the tube. **Code "1" for ER visit.**

P7. Physician Visits (14-day look back)

Intent: To record the **number of days** during the last 14-day period a physician has examined the resident (or since admission if less than 14 days ago). Examination can occur in the facility or in the physician's office. In some cases the frequency of physician's visits is indicative of clinical complexity.

Definition: **Physician** - Includes an MD, DO (osteopath), podiatrist, or dentist who is either the primary physician or consultant. Also include an authorized physician assistant or nurse practitioner (who is not employed by the nursing facility) working in collaboration with the physician. Does not include visits made by Medicine Men nor licensed psychologists (PhD). The licensed psychologist (PhD) visits may be recorded in P2b.

Physician Exam - May be a partial or full exam at the facility or in the physician's office. This does not include exams conducted in an emergency room. If the resident was examined by a physician during an unscheduled emergency room visit, record the number of times this happened in the last 90 days in Item P6, "Emergency Room (Visits)"

Coding: Enter the number of days the physician examined the resident. If none, enter "**0**".

Clarification:

- If a resident is evaluated by a physician off-site (e.g., while undergoing dialysis or radiation therapy), it can be coded as a physician visit. Documentation of the physician's evaluation should be included in the clinical record. The physician's evaluation can include partial or complete

examination of the resident, monitoring the resident for response to the treatment, or adjusting the treatment as a result of the examination.

P8. Physician Orders (14-day look back)

Intent: To record the **number of days** during the last 14-day period (or since admission, if less than 14 days ago) in which a physician has changed the resident's orders. In some cases the frequency of physician's order changes is indicative of clinical complexity.

Definition: **Physician** - Includes MD, DO (osteopath), podiatrist, or dentist who is either the primary physician or a consultant. Also includes authorized physician assistant or nurse practitioner working in collaboration with the physician. Orders written by physician assistants or nurse practitioners employed by the facility are not included.

Physician Orders - Includes written, telephone, fax, or consultation orders for new or altered treatment. Does NOT include standard admission orders, return admission orders, renewal orders, or clarifying orders without changes. Orders written on the day of admission as a result of an unexpected change/deterioration in condition or injury are considered as new or altered treatment orders and should be counted as a day with order changes.

Coding: Enter the number of days on which physician orders were changed. Do not include order renewals without change. If no order changes, enter "**0**".

Clarifications:

- A sliding scale dosage schedule that is written to cover different dosages depending on lab values, does not count as an order change simply because a different dose is administered based on the sliding scale guidelines.

- Do not count visits or orders prior to the date of admission or reentry. Do not count return admission orders or renewal orders without changes. And do not count orders written by a pharmacist. The prohibition against counting standard admission or readmission orders applies regardless of whether the orders are given at one time or are received at different times on the date of admission or readmission.

- A monthly Medicare Certification is a renewal of an existing order and should not be included when coding this item.

- If a resident has multiple physicians; e.g., surgeon, cardiologist, internal medicine, etc., and they all visit and write orders on the same day, the MDS must be coded as 1 day during which a physician visited, and 1 day in which orders were changed.

- Orders requesting a consultation by another physician may be counted. However, the order must be reasonable; e.g., for a new or altered treatment. An order written on the last day of the MDS observation period for a consultation planed 3-6 months in the future should be carefully reviewed. Orders written to increase the resident's RUG-III classification and facility payment are not acceptable.

- When a PRN order was already on file, the potential need for the service had already been identified. Notification of the physician that the PRN order was activated does not constitute a new or changed order and may not be counted when coding this item.

- Orders for transfer of care to another physician may not be counted.

P9. Abnormal Lab Values (90-day look back)

Intent: To document whether the resident had any abnormal laboratory values during the last 90 days or since admission to the nursing facility. This item refers only to laboratory tests performed after admission to the nursing facility. "Abnormal" refers to laboratory values that are abnormal when compared to standard values, not abnormal for the particular resident.

Example

An elevated prothrombin time in a resident receiving coumadin therapy is coded "1" for Yes (Abnormal) even though this may be the desired effect.

Process: Check medical records, especially laboratory reports.

Coding: Enter "**0**" if no abnormal value was noted in the record, and "**1**" if the resident has had at least one abnormal laboratory value. Abnormal blood glucose levels, including levels obtained via finger-sticks are included in this item.

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

Q1. Discharge Potential

Intent: To identify residents who are potential candidates for discharge within the next three months. Some residents will meet the "potential discharge" profile at admission; others will move into this status as they continue to improve during the first few months of residency. Section Q provides data on discharge potential. Depending on the resident's clinical status and circumstances, additional assessment to determine why the resident is not a candidate for discharge at this time and what plan can be implemented to improve discharge potential may be warranted.

Definition: **Discharge** - Can be to home, another community setting, another care facility, or a residential setting. A prognosis of death should not be considered as an expected discharge.

Support Person - Can be a spouse, family member, or significant other.

Process: For new and recent admissions, ask the resident directly. The longer the resident lives at the facility, the tougher it is to ask about preferences to return to the community. After one year of residency, many persons feel settled into the new lifestyle at the facility. Creating unrealistic expectations for a resident can be cruel. Use careful judgment. Listen to what the resident brings up (e.g., Calls out, "I want to go home"). Ask indirect questions that will give you a better feel for the resident's preferences. For example, say, "It's been about 1 year that we've known each other. How are things going for you here at (facility)."

Consult with primary care and social service staff, the resident's family, and significant others. Review clinical records. Discharge plans are often recorded in social service notes, nursing notes, or medical progress notes.

Coding:

a. **Resident Expresses/Indicates Preference to Return to the Community** - Enter "**0**" for No or "**1**" for Yes.

b. **Resident has a Support Person who is Positive Towards Discharge** - Enter "**0**" for No or "**1**" for Yes.

c. **Stay Projected to be of a Short Duration** - Discharge projected within 90 days (do not include expected discharge due to death). Enter "**0**" for No, "**1**" for within 30 days, "**2**" for within 31-90 days, or "**3**" for discharge status uncertain.

Examples

Mrs. F is a 65 year-old married woman who sustained a CVA 2 months ago. She was admitted to the nursing facility one week ago from a rehabilitation facility for further rehab, particularly for transfer, gait training, and wheelchair mobility. Mrs. F is extremely motivated to return home. Her husband is supportive and has been busy making their home "user friendly" to promote her independence. Their goal is to be ready for discharge within 2 months.

Discharge Potential	**Coding**
a. Resident expresses/indicates preference to return to the community.	1 (Yes)
b. Resident has a support person who is positive towards discharge.	1 (Yes)
c. Stay projected to be of a short duration - discharge projected within 90 days (do not include expected discharge due to death).	2 (within 31-90 days)

Mrs. D is a 67 year-old widow with end-stage metastatic cancer to bone with pathological fractures. Currently her major problems are pain control and confusion secondary to narcotics. Mrs. D periodically calls out for someone to take her home to her own bed. Her daughter is unwilling and unable to manage her hospice care at home. Because of the fractures, Mrs. D is totally dependent in all ADLs except eating (she can hold a straw).

Discharge Potential	**Coding**
a. Resident expresses/indicates preference to return to the community	1 (Yes)
b. Resident has a support person who is positive towards discharge	0 (No)
c. Stay projected to be of short duration - discharge projected within 90 days (do not include expected discharge due to death).	0 (No)

Rationale for coding:
Although Mrs. D is near death, you should apply a code of "0" (No).
This MDS item instructs you "do not include expected discharge due to death."

(continued on next page)

Examples
(continued)

Mr. S is a 70 year-old married gentleman who was admitted to the facility 2 weeks ago from the hospital following surgical repair of a left hip fracture. Mr. S has a long history of alcoholism and cirrhosis of the liver. His daughter reports that when he is drinking he is abusive towards his wife of 40 years. Though he has a strong wish to return home, his wife states she can't take it anymore and doesn't want him to return home. He has basically worn out all his family options. Other social support options are being explored. At this time plans for discharge remain uncertain.

Discharge Potential	**Coding**
a. Resident expresses/indicates preference to return to the community.	1 (Yes)
b. Resident has a support person who is positive towards discharge.	0 (No)
c. Stay projected to be of a short duration - discharge projected within 90 days (do not include expected discharge due to death).	3 (Uncertain)

Q2. Overall Change in Care Needs (90-day look back)

Intent: To monitor the resident's overall progress at the facility over time. Document changes as compared to his or her status of 90 days ago (or since last assessment if less than 90 days ago). This item asks for a snapshot of "today" as compared to 90 days ago (i.e., a comparison of 2 points in time). If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

Definition: **Overall Self-Sufficiency** - Includes self-care performance and support, continence patterns, involvement patterns, use of treatments, etc.

Process: Review clinical record, transmittal records (if new admission or readmission), previous MDS assessments (including Quarterly assessment), and care plan. Discuss with direct caregivers.

Coding: Record the number corresponding to the most correct response. Enter "**0**" for No change, "**1**" for Improved (receives fewer supports, needs less restrictive level of care), or "**2**" for Deteriorated (receives more support).

Examples

Mr. R is a 90 year-old comatose gentleman admitted to the facility from a 6 months stay at another nursing facility to be closer to his wife's residence. His condition has remained unchanged for approximately 6 months. **Code "0" for No change.**

Mrs. T has a several year history of Alzheimer's disease. In the past four months her overall condition has generally improved. Although her cognitive function has remained unchanged, her mood is improved. She seems happier, less agitated, sleeps more soundly at night, and is more socially involved in daily activity programming. **Code "1" for Improved.**

Mr. D also has a several year history of Alzheimer's disease. Although for the past year he was quite dependent on others in most areas, he was able to eat and walk with supervision until recently. In the past 90 days he has become more dependent. He no longer feeds himself. Additionally, he fell two weeks ago and has been unable to learn how to use a walker. He requires a 2-person assist for walking even short distances. **Code "2" for Deteriorated.**

SECTION R.
ASSESSMENT INFORMATION

R1. Participation in Assessment

Intent: To record the participation of the resident, family and/or significant others in the assessment, and to indicate reason if the resident's assessment is incomplete.

Definition: **Family** - A spousal, kin (e.g., sibling, child, parent, nephew), or in-law relationship.

Significant Other - May include close friend, partner, housemate, legal guardian, trust officer, or attorney. Significant other does not, however, include staff at the nursing facility.

Process: Preparing residents and family members to participate in the care planning process begins with assessment. When staff members explain the assessment process to a resident, they should also explain that the outcome of assessment is care delivery guided by a care plan. Every assessment team member can establish an expectation of resident participation by asking for and respecting the resident's perspective during assessment.

Asking family members about their expectations of the nursing facility and their concerns during the assessment process can prove beneficial. Relatives may need to talk to a staff member or they may need information. Some family concerns and expectations can be appropriately addressed in the care planning conference. Discussing these matters with the family during the assessment process can assist in maintaining a focus on the resident during the care planning meeting.

Staff should consider some important aspects of resident and/or family participation in assessment and care planning. Attention to seating arrangements that will facilitate communication is necessary for several reasons:

- To keep the resident from feeling intimidated and/or powerless in front of professionals.
- To accommodate any communication impairments.
- To minimize any tendencies for family members to dominate the resident in the conference yet encourage them to support the resident if that is needed.
- To facilitate nonverbal support of the resident by staff with whom the resident is close.

Verbal communication should be directed to the resident, even when the resident is cognitively impaired. The terms used should be tailored to facilitate understanding by the resident. The resident's opinions, questions, and responses to the developing care plan should be solicited if they are not forthcoming.

Coding:

a. Resident - Enter zero "**0**" for No or "**1**" for Yes to indicate whether or not the resident participated in the assessment. This item should be completed last.

b. Family - Enter zero "**0**" for No or "**1**" for Yes to indicate whether or not the family participated; enter "**2**" for No family.

c. Significant Other - Enter "**0**" for No or "**1**" for Yes to indicate whether or not a significant other participated; enter "**2**" for None if there is no significant other.

R2a. and b. Signatures of Persons Coordinating the Assessment

Intent: Federal regulations at 42 CFR 483.20 (i) (1) and (2) require each individual who completes a portion of the MDS assessment to sign and certify its accuracy in Item AA9. These regulations also require the RN Assessment Coordinator to sign, date and certify that the assessment is complete in Items R2a and R2b.

Process: Each staff member who completes any portion of the MDS must sign and date (at AA9) the MDS and indicate beside the signature which portions they completed. Two or more staff members can complete items within the same section of the MDS. The RN Assessment Coordinator must not sign and attest to completion of the assessment until all other assessors have finished their portions of the MDS. The RN Assessment Coordinator is not certifying the accuracy of portions of the assessment that were completed by other health professionals.

Coding: All persons completing part of this assessment, including the RN Assessment Coordinator, must sign their names in the appropriate locations at Item AA9. To the right of the name, enter title and the letters that correspond to sections of the MDS for which the assessor was responsible, and also enter the date on which the form is signed. Federal regulation requires the RN Assessment Coordinator to sign and thereby certify that the assessment is complete. Use the actual date the MDS was completed, reviewed, and signed, even if it is after the resident's date of discharge. If, for some technical reason, such as computer or printer breakdown, the MDS cannot be signed on the date it is completed, it is appropriate to use the actual date that it is signed. It is recommended that staff document the reason for the discrepancy in the clinical record.

Clarifications:

- All persons completing part of the assessment must attest to the accuracy of the sections they completed. Completing a portion of the MDS is not the same as transcribing information. For example, if an RN enters the therapy time from the therapy log to the MDS, the therapist is still responsible for attesting to the accuracy of the data. The therapist must date and sign the therapy sections of the MDS.

- The use of signature stamps is allowed. The State Operation Manual Transmittal No. 274, survey protocol, F386, has the following guidance to surveyors on this topic: "When rubber stamp signatures are authorized by the facility's management, the individual whose signature the stamp represents shall place in the administrative offices of the facility a signed statement to the effect that he/she is the only one who has the rubber stamp and uses it. A list of computer codes and written signatures must be readily available and maintained under adequate supervision." The State and facility may have additional policies or regulations that apply.

- The text of the regulation CFR 42 483.20(i)(1)(ii) states, "Each assessment must be conducted or coordinated by a registered nurse who signs and certifies the completion of the assessment." Further, CFR 42 483.20(i)(2) states, "Each individual who completes a portion of the assessment must sign, date and certify the accuracy of that portion of the assessment in Item AA9."

  For facilities that use a sign-in form for care planning and MDS completion, the facility would need to have a written policy that explains how the sign-in

process and format are used. It would have to provide attestation by the registered nurse regarding the completion of the assessment, and for each individual, who must certify the accuracy of the portion of the assessment that they completed. The State may have additional regulations that apply.

Section R. - Assessment/Discharge Information:

R3. Discharge Status (Item appears on the Discharge Tracking Form)

Coding: **a.** Code for resident disposition on discharge.

Definition:

1. **Private Home or Apartment with No Health Services** - Any house, condominium, or apartment in the community whether owned by the resident or another person. Also included in this category are retirement communities, and independent housing for the elderly.

2. **Private Home/Apt. with Home Health Services** - Includes skilled nursing, therapy (e.g., physical, occupational, speech), nutritional, medical, psychiatric and home health aide services delivered in the home. Does not include the following services unless provided in conjunction with the services previously named: homemaker/personal care services, home delivered meals, telephone reassurance, transportation, respite services or adult day care.

3. **Board and Care/Assisted Living/Group Home** - A non-institutional community residential setting that includes services of the following types: home health services, homemaker/personal care services, or meal services.

4. **Nursing Home** - An institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for injured, disabled or sick persons.

5. **Acute Care Hospital** - An institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled or sick persons.

6. **Psychiatric Hospital, MR/DD Facility** – A psychiatric hospital is an institution that is engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill patients. An MR/DD facility is an institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals who are mentally retarded or who have developmental disabilities.

7. **Rehabilitation Hospital** - An Inpatient Rehabilitations Hospital (IRF) that is engaged in providing, under the supervision of physicians, rehabilitation services for the rehabilitation of injured, disabled or sick persons.

8. **Deceased**

9. **Other** - Includes hospices and chronic disease hospitals.

8. **Other**

Coding: **b. Optional State Code**

R4. Discharge Date (Item appears on the Discharge Tracking Form)

Coding: Date of death or discharge. *Use all boxes*. For a one-digit month or day, place a zero in the first box. For example: February 3, 2002, should be entered as:

0	2
Month	

0	3
Day	

2	0	0	2
Year			

SECTION S.
STATE-DEFINED SECTION

SECTION S IS RESERVED FOR ADDITIONAL STATE-DEFINED ITEMS. THERE IS NO SECTION S IN THE FEDERAL VERSION 2.0 MDS FORM. YOUR STATE MAY CHOOSE TO DESIGNATE A SECTION S.

SECTION T.
THERAPY SUPPLEMENT FOR MEDICARE PPS

Nursing facilities are required to complete Section T. if included in the State's RAI, for all comprehensive assessments: Admission, SCSA, and Annual reassessment. Some states may also require facilities to complete this section for each Quarterly assessment. Contact your State RAI Coordinator for State-specific requirements.

T1. Special Treatments and Procedures

a. RECREATION THERAPY (7-day look back)

Intent: To record the **(A) number of days** and **(B) total number of minutes** recreation therapy was administered (for at least 15 minutes a day) in the last 7 days.

Definition: **Recreation Therapy** - Therapy ordered by a physician that provides therapeutic stimulation beyond the general activity program in a facility. The physician's order must include a statement of frequency, duration and scope of the treatment. Such therapy must be provided by a state licensed or nationally certified Therapeutic Recreation Specialist or Therapeutic Recreation Assistant. The Therapeutic Recreation Assistant must work under the direction of a Therapeutic Recreation Specialist.

Process: Review the resident's clinical record and consult with the qualified recreation therapists.

Coding: **Box A:** In the first column, enter the number (#) of days the therapy was administered for 15 minutes or more in the last seven days. Enter "0" if none.

Box B: In the second column, enter the total number (#) of minutes recreational therapy was provided in the last seven days. The time should include only the actual treatment time (not resident time waiting for treatment or therapist time documenting a treatment). Enter "0" if none.

b. ORDERED THERAPIES (first 14 days)

Skip these items unless this is a Medicare 5-Day assessment, or a Medicare Readmission/Return assessment.

Coding: **Ordered Therapies** – Code "1", Yes, if the physician has ordered any of the following therapy services to begin in the first 14 days of the stay – physical therapy, occupational therapy, or speech pathology services. If No, enter "0" and skip to T2.

Intent: To recognize ordered and scheduled therapy services [physical therapy (PT), occupational therapy (OT) and speech pathology services (SP)] during the early days of the resident's stay. Often therapies are not initiated until after the end of the observation assessment period. For the Medicare 5-Day or Readmission/Return assessment, this section provides an overall picture of the amount of therapy that a resident will likely receive through the fifteenth day from admission.

Process: For Item T1b: Review the resident's clinical record to determine if the physician has ordered one or more of the medically necessary therapies to begin in the first 14 days of stay. Therapies include physical therapy (PT), occupational therapy (OT), and/or speech pathology services. If not, skip to Item T2. If orders exist, consult with the therapists involved to determine if the initial evaluation is

completed and therapy treatment(s) has been scheduled. If therapy treatment(s) will **not** be scheduled, skip to Item T3.

If the resident is scheduled to receive at least one of the therapies, have the therapist(s) calculate the total number of days through the resident's fifteenth day since admission to Medicare Part A when at least one therapy service will be delivered. Then have the therapist(s) estimate the total PT, OT, and SP treatment minutes that will be delivered through the fifteenth day of admission to Medicare Part A.

c. ESTIMATE OF NUMBER OF DAYS (first 14 days through day 15)

Coding: **Estimate of Number of Days -** Enter the number (#) of days at least one therapy service can be expected to have been delivered through the resident's fifteenth day of admission. Count the days of therapy already delivered from Item P1a, b, and c. Calculate the expected number or days through day 15, even if the resident is discharged prior to day 15. If orders are received for more than one therapy discipline, enter the number of days at least one therapy service is performed. For example, if PT is provided on MWF, and OT is provided on MWF, the MDS should be coded as 3 days, not 6 days.

d. ESTIMATE OF NUMBER OF MINUTES (first 14 days through day 15)

Coding: **Estimate of Number of Minutes -** Enter the estimated **total** number of therapy minutes (across all therapies) it is expected the resident will receive through the resident's fifteenth day of admission. Include the number of minutes already provided from MDS Items P1ba(B), P1bb(B), and P1bc(B). Calculate the expected number of minutes through day 15, even if the resident is discharged prior to day 15.

Example of Ordered Therapies on Medicare 5-Day Assessments

Mr. Z was admitted to the nursing facility late Thursday afternoon. The physician's orders for both physical therapy and speech language pathology evaluation were obtained on Friday. Both therapy evaluations were completed on Monday and physical and speech therapy were scheduled to begin on Tuesday. Physical therapy was scheduled 5 days a week for 60 minutes each day. Speech therapy was scheduled for 3 days a week for 60 minutes each day. The RN Assessment Coordinator identified Monday as the end of the observation assessment period for this Medicare 5-Day assessment. Within the 15 days from the resident's admission date (Thursday), the resident will receive 8 days of physical therapy (480 minutes) and 4 days of speech therapy (240 minutes) for a total of 720 minutes in the fifteen days.

Enter "8" in Item T1c for the number of days that at least one therapy service is expected to be delivered.

Because physical therapy was scheduled more frequently than speech therapy, the total number of days of physical therapy would be used.

Enter "720" in Item T1d for the estimated total number of minutes that both physical therapy and speech therapy are expected to be delivered.

Mrs. C was admitted to the facility Tuesday with an evaluation order for all three therapies. The physical therapist completed the evaluation for physical therapy and scheduled treatment to begin on Thursday, five days a week for 30 minutes each day. The occupational therapist completed the evaluation and scheduled therapy to begin on Monday, 3 days a week for one hour each day. The speech language pathologist's evaluation did not recommend speech therapy for the resident so speech therapy was not scheduled. The RN Assessment Coordinator identified Monday as the end of the observation assessment period. Within the observation assessment period, the resident received 3 days of physical therapy for a total of 90 minutes. This was recorded in Item P1bc, A and B of the MDS assessment. The resident received one occupational therapy treatment for a total of 60 minutes, which was also recorded in Item P1b, A and B. It was expected that Mrs. C would receive 6 more days of physical therapy within the 15 days after the resident's admission for a total of 180 minutes and 3 more days of occupational therapy within the 15 days after the resident's admission for a total of 180 minutes.

Enter "9" in Item T1c for the number of days that at least one therapy service is expected to be delivered.

Enter "510" in Item T1d for the estimated total number of minutes that both physical therapy and occupational therapy is expected to be delivered.

T2. Walking when most self-sufficient (7-day look back)

Intent: Physical therapy treatment plans and nursing rehabilitation programs are often implemented to improve a resident's ability to walk. This includes residents with different problems (e.g. stroke, Parkinson's disease, hip replacement) and at different stages of recovery (e.g. 1 week post-hip fracture versus 3 weeks post-hip fracture). It is important to monitor the gait pattern and walking progress for residents and how functional walking is integrated into the resident's activities of daily living on the nursing unit.

Four important walking components to be monitored are the **distance** a resident walks, the amount of **time** it takes to walk that distance, and the amount of **assistance** and **support** received. Assessment of the resident's ability to walk using these four components should be viewed in combination with information in Section G (walking in room, walking in corridor, locomotion on unit, balance test, functional range of motion, modes of locomotion and transfer, and rehabilitation potential); Section I (diagnoses that impact ability to walk such as cerebral palsy, hip fracture, stroke); and Section J (unsteady gait). This information will provide a picture of the resident's problems and level of functioning for comparison to the most self-sufficient walking episode. This information will assist all members of the interdisciplinary care team to differentiate the resident's "best walking effort" and the resident's usual walking performance. Discussions between the physical therapist working with the resident on walking and the RN Assessment Coordinator regarding these differences should lead to better coordination of care and foster continuity of physical therapy treatment for the resident on the nursing unit.

Assessment of the resident's most self-sufficient walking episode can be used to evaluate 1) the effectiveness of physical therapy and nursing rehabilitation, 2) the continued need for therapy and nursing rehabilitation, and 3) maintenance of walking ability after therapy or nursing rehabilitation was discontinued.

Complete Item 2 when the following conditions are present. Otherwise, skip to Item 3.

- **ADL self-performance score for TRANSFER (G1bA) is 0, 1, 2, or 3**

AND

- **Resident receives physical therapy (P1bc) involving gait training;**

OR

- **Physical therapy is ORDERED for gait training (T1b)**

OR

- **Resident is receiving nursing rehabilitation for walking (P3f)**

OR

- **Physical therapy involving gait training has been discontinued within the past six months.**

Definition: **Most Self-Sufficient Episode** - In the last seven days, the episode in which the resident used the LEAST amount of assistance and support while walking the longest and farthest **without sitting down.** The most self-sufficient episode can include physical help from others or assistive devices. Only episodes using a safe, functional gait should be used in determining the walking episode that was the most self-sufficient.

Assistive Devices: Prostheses, different types of canes and walkers, crutches, splints, parallel bars, and pushing a wheel chair for support.

Examples for Most Self Sufficient Episode

Mrs. G had a hip replacement three weeks ago and was admitted to the nursing facility one week after the surgery. During the 7-Day assessment period of the initial comprehensive assessment, Mrs. G could only stand and transfer from bed to chair on the nursing unit with the assistance of one person. Physical therapy was initiated several days after admission for gait training. By the sixth day of admission, Mrs. G could walk two lengths of the parallel bars (20 feet) with stand by assistance from the therapist. The physical therapists and RN assessment coordinator conferred and together determined that Mrs. G's most self-sufficient walking episode took place in therapy using the parallel bars.

Following intensive physical therapy for gait training for weakness and paralysis from a stroke, Mr. T was discharged from physical therapy with the ability to walk using an appropriate and safe gait pattern, using a short leg brace and a quad cane. Mr. T's revised care plan includes a nursing rehabilitation program for walking. His walking rehabilitation program requires a nursing assistant to walk with Mr. T in the morning after breakfast and after dinner for 15 minute walking sessions using a measured "walking route" on the nursing unit. Mr. T's stamina during the walking sessions varied daily during the 7-Day assessment period. Sometimes he could only walk several feet before needing to sit down. On three occasions, Mr. T walked half the length of the corridor (75 feet) in 5 minutes without sitting down and using the gait pattern he was taught. This was his most self-sufficient walking episode.

During a brief meeting during morning report, the physical therapist, nursing staff on 2 South, and the RN assessment coordinator determined Mr. A's most self-sufficient walking episode during the last seven days. It was reported that Mr. A walked 50 feet in 7 minutes with a walker, cueing, and physical guidance on the nursing unit and walked 60 feet in 10 minutes with a walker and cueing for correct heel strike in physical therapy. The staff agreed that the walking episode in physical therapy was Mr. A's most self-sufficient episode.

Mrs. W requires weight bearing support (G1bA=3) and the assistance of two persons (G1bB=3) to transfer her from the bed to a chair. Due to her obesity and overall weakness, the nursing staff cannot safely walk her on the nursing unit, therefore she received a code of "8", "activity did not occur" for walking in room (G1cA) and walking in corridor (G1dA). However, Mrs. G is able to walk the length of the parallel bars with the assistance of two persons when she is in physical therapy, which would be Mrs. G's most self-sufficient walking episode.

Process: There are four components to determining a resident's most *self-sufficient walking episode*: **distance, time, self-performance, and support**. During the 7-Day assessment period, it is likely that nursing and therapy staff will have had numerous opportunities to assess the resident's walking status. Staff is encouraged to use all of the assessment days to determine the resident's most self-sufficient walking episode. Needless to say, it is important that all staff observes the resident and contributes to the determination the resident's most self-sufficient walking episode during the 7-Day assessment period.

During each shift report, staff should be informed which residents are being assessed for their most self-sufficient walking effort. This will remind staff to look for episodes when the resident does <u>better</u> than usual, to observe the distance the resident walks, check the time it takes for the resident to walk that distance, and note the support and assistance that the resident requires. For recently admitted residents receiving physical therapy for gait training, the most self sufficient walking episode will frequently occur during a physical therapy session. However, the best walking effort can occur on the nursing unit, off the unit, in therapy, or even outside the facility.

Distance Walked: Determining the distance a resident walks involves knowing the distance between usual places the resident may walk (e.g. number of feet from the bed to the toilet room; number of feet from the resident's room to the dining room, day room, or nurses station). Some facilities may have a section of the corridor designated for walking residents that is measured for distance. Some facilities may be able to use floor tiles or ceiling tiles in determining the distance a resident walks. Take time to determine the distances associated with typical walking places in your facility and communicate these distances to staff. For example, if the distance from the resident's bed to a toilet room in your facility is 8 feet and the nursing assistant reported that the resident walked from the bed to the toilet room, it can be interpreted that the resident walked 8 feet during that walking episode.

Time Walked: Staff should determine the time it takes a resident to walk a distance using a timepiece with a second hand.

Self-Performance in Walking: This assessment item is similar to the self-performance ADL items in Section G, except this item refers **only to the ONE most self-sufficient walking episode** in the past seven days, rather than ALL of the walking episodes in the past seven days.

Walking Support Provided: This assessment item is OPPOSITE the ADL support items in Section G. In determining a resident's most self-sufficient walking episode, the episode with the LEAST amount of support used is identified. Section G requests scoring the MOST amount of support used for an ADL activity during any episode over the last 7 days.

Coding:

a. Furthest Distance Walked - For the most self-sufficient episode using a safe and functional gait pattern, record the distance that the resident walked. Use the following codes:

0. 150 or more feet
1. 51-149 feet
2. 26-50 feet
3. 10-25 feet
4. Less than 10 feet

b. Time Walked - For the same episode (T3a), record the time it took the resident to walk the distance. Use the following codes:

0. 1-2 minutes
1. 3-4 minutes
2. 5-10 minutes
3. 11-15 minutes
4. 16-30 minutes
5. 31 or more minutes

c. Self-Performance in Walking - For the same episode (T3a), record the amount of assistance the resident received during the walking episode. Use the following codes:

0. INDEPENDENT - No help or oversight provided while walking.
1. SUPERVISION - Oversight, encouragement, or cuing provided while walking.
2. LIMITED ASSISTANCE - Resident highly involved in walking; received physical help in guided maneuvering of limbs or other non weight-bearing assistance.
3. EXTENSIVE ASSISTANCE - Resident received weight-bearing assistance while walking.

d. Walking Support Provided - For the same episode (T3a), record the amount of support the resident received during the walking episode. Use the following codes:

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two or more persons physical assist

e. Parallel Bars Used During Walking - For the same episode (T3a), record if parallel bars were used. Code "0" if parallel bars were NOT used and "1" if parallel bars were used.

CODING EXAMPLES FOR WALKING WHEN MOST SELF SUFFICIENT

Mrs. D was admitted to the nursing facility 1 month ago for rehabilitation following a CVA. She has left sided hemiplegia and receives physical therapy 5 days a week for a 45-minute session twice daily. Mrs. D enjoys her PT sessions and puts forth her best efforts in walking when her therapist is present. During the last 7 days, Mrs. D's most self-sufficient episode was during a physical therapy session when she walked the length of the hallway outside the physical therapy room (approximately 50 feet) in 15 minutes without sitting down. Mrs. D used a short leg brace to prevent foot drop and a quad cane for support. The physical therapist walked beside Mrs. D, encouraging her and cueing her to pick up her left foot, but not providing physical support.

Code a (furthest distance walked) as "2"

Code b (longest time) as "3"

Code c (self-performance) as "1"

Code d (walking support provided) as "0"

****

Mr. G was admitted to the nursing facility following a lengthy hospitalization related to injuries sustained in a motor vehicle accident. Mr. G received physical therapy for 8 weeks to strengthen his lower extremities. Physical therapy was discontinued last week. Mr. G tires during the day, requiring more assistance with ambulation as the day progresses. During the morning, Mr. G walks from his bed to the toilet room (8 feet) with oversight from a staff person. It takes about 6 minutes for Mr. G to reach the toilet room. He uses a brace, that the staff put on for him, on his right leg and a walker.

During the night shift, Mr. G has much difficulty in bearing weight and manipulating his lower extremities. To walk to the toilet room, two nursing assistants are needed to provide weight-bearing support and to help Mr. G position his legs in taking steps. It takes approximately 6 minutes to reach the toilet room.

Code a (furthest distance) as "4"

Code b (longest time) as "2"

Code c (self-performance) as "1"

Code d (walking support provided) as "1"

T3. Case Mix Group

Intent: Records the RUG-III Classification calculated from the facility software.

a. **Medicare**
The software calculated RUG-III Classification for the Medicare program using the 44 Group Version 5.12. The first three characters entered in the boxes represent one of the 44 RUG-III groups. The last two numbers are an indicator of the version of the RUG-III Classification system. Currently, this version is **07**. This **07** comes directly from the software and will appear on every assessment.

b. **State**
The software calculated RUG-III Classification for the State case mix field using the State-specified RUG-III Classification system. For states using the RUG-III Classification system for case mix reimbursement, this item may be required. States have the option of using either the 34 or 44 RUG-III Classification systems, or a different version of the RUG-III Classification system. The first three characters entered in the boxes represent one of the RUG-III groups. This could vary from the Medicare case mix field if the state is using the 34 RUG-III Classification system. The last two numbers may vary depending on the version of the RUG-III Classification system specified in the state. Please contact your State representatives for your State requirements.

SECTION U.
MEDICATIONS (7-day look back)

PLEASE NOTE: This section is not required by CMS. Some states have required completion of Section U. Please contact your State RAI Coordinator for State-specific instructions.

Nursing facility residents are highly susceptible to adverse drug reactions and drug interactions. Polypharmacy is the use of two or more medications for no apparent reasons or for the same purpose. Polypharmacy also occurs when a medication is used to treat an adverse reaction from another medication. Polypharmacy can occur in nursing facilities when there is no regular and careful monitoring of residents' prescribed medications.

Intent: This section will assist staff in identifying potential problems related to polypharmacy, drug reactions and interactions. Further, this section can also help staff to identify potential physical and emotional problems a resident may be experiencing. For example, reviewing and documenting the frequency a resident uses a PRN pain medication, sleeping medication, or laxative may lead the interdisciplinary team to do further assessment related to underlying causes associated with the use of PRN medications. Many of the RAPs and Triggers refer to assessment of medications in which this section would be very helpful.

In addition to using the medication information collected in Section U for resident care planning purposes, this section can be integrated into a facility's quality assurance program to monitor for quality care issues such as polypharmacy, overuse of different medications, and medication administration errors and omissions.

Definition: **Amount Administered** - The number of tablets, capsules, suppositories, or amount of liquid (cc's, mls, units) **per dose** that is administered to a resident.

NDC - The National Drug Code (NDC) is a standardized system for coding medications. An individual NDC provides coded information on the drug name, dose, and form of the drug.

Medication Administration Record (MAR) - The part of the resident's clinical record that is used by the nurse administering medications to record the medication administered. The MAR typically is the form or document used specifying the medication, dose, frequency, and route for each medication that a resident is to receive on a scheduled or PRN basis.

Process: Recording all of the information required in this section can be done efficiently by having the following information: 1) current physician order sheets; 2) current Medication Administration Record (MAR), 3) NDC codes. Use the Medication Administration Record (MAR) as your **primary** document for identifying all medications administered in the last seven days. Check the physician's order sheet to determine if any medications had recently been ordered.

In some facilities, the pharmacist may complete some portions of Section U, particularly the NDC codes and the amount administered. The pharmacy may also be able to supply you with the NDC codes for the medications ordered for each resident. Talk to the pharmacist for your facility and engage their participation in assisting with the completion of this section. If the pharmacist does not complete any portions of the medication section of the MDS, you will need to consult the list of NDC codes. The manual provides the NDC codes for medications frequently used in nursing facilities. In addition, NDC codes can be found in the *Physicians Drug Reference (PDR)* or you may be able to obtain a list of NDC codes from your pharmacy.

Take special care to ensure that you have identified and recorded all medications that were administered in the last 7 days. Often residents can have several MAR pages, especially if medications have been discontinued and new ones ordered or if there are a lot of PRN medications ordered. Recheck the MAR at least twice to avoid missing any medications administered in the last seven days. Make sure you count medications that may have been discontinued, but were administered in the last seven days.